DR GUN SUK CHYN & ORS A

v.

KARTAR KAUR JAGEER SINGH & ANOR

COURT OF APPEAL, PUTRAJAYA B
ABDUL MALIK ISHAK JCA
ALIZATUL KHAIR OSMAN JCA
MOHD ZAWAWI SALLEH JCA
[CIVIL APPEAL NO: N-01-706-12-2011]
11 OCTOBER 2013 C

TORT: *Negligence - Medical negligence - Duty of care - Breach - Test for determining duty and standard of care of medical practitioner - Patient became blind after treatment - Whether blindness caused by treatment - Whether diagnosis and treatment proper and reasonable - Whether there had been reasonable disclosure on common side effects of treatment - Causative link between treatment and injury - Whether proved - Whether medical practitioner liable in negligence when another doctor would have prescribed different medicine or treatment* D

The second respondent ('Ranjini') was the daughter of the first respondent. Ranjini was a patient of the Seremban Hospital and she was treated by the first appellant/defendant ('Dr. Gun'), a consultant physician and rheumatologist. On 16 May 2003, Ranjini was warded at Seremban Hospital with complaints of persistent cough and fever. Various tests were conducted by the specialists but the cause of the illness could not be identified. On 19 August 2003, Dr. Gun, after reviewing the test results and taking into consideration the fact that Ranjini stayed at the school hostel where there were a lot of cats, made the provisional diagnosis of 'toxoplasmosis', an infection due to the parasite 'toxoplasma gondii' which could be found in cat faeces. Dr. Gun prescribed the drug 'Fansidar' to Ranjini which was the drug of choice for toxoplasmosis, even today. The dosage of the drug Fansidar prescribed to Ranjini was decided after consulting the hospital's pharmacist. Dr. Gun testified that she did inform Ranjini and the first respondent about the common side effects of Fansidar. However, Ranjini's condition did not improve. On 3 September 2003, Ranjini developed Steven-Johnson Syndrome. At the request of Ranjini's father, she was sent to the University Malaya Medical Centre ('UMMC') for further treatment. Ranjini became blind in E F G H I

A both eyes. Upon treatment, she regained vision in her right eye but her left eye remained blind. Hence, an action in medical negligence was brought by the respondents against the appellants. The High Court Judge allowed the respondents' claim and ordered damages to be assessed by the Senior Assistant Registrar. The B appellants appealed against the said decision.

Held (allowing appeal with costs):

(1) In relation to the issue of what is the duty and standard of care of a medical practitioner in a medical negligence case, in C our jurisprudence, *Foo Fio Na v. Dr. Soo Fook Mun & Anor* is the guiding light for the court to follow. The *Bolam* test should not apply to all aspects of medical negligence. According to *Foo Fio Na (supra)*, the *Bolam* test has 'no relevance'. Although English law accepts that the *Bolam* test D applies to diagnosis and treatment, yet it is reluctant to extend the *Bolam* test. (para 46)

(2) In ascertaining the standard of care of a medical practitioner in a medical negligence appeal, it is always prudent to accept E the opinions of doctors specially skilled in medical science, to assist the court in arriving at a just decision after evaluating the evidence adduced by the parties. (para 94)

(3) This was not a case where Dr. Gun decided to prescribe F Fansidar to Ranjini without consulting other consultants. Rather, it was a case where after thorough investigations and discussions, the diagnosis and treatment were made. (para 104)

G **(4)** The prescription and consumption of Fansidar was not the cause of Ranjini contracting the Steven-Johnson Syndrome. The causal connection between medical negligence and the 'damage' alleged had not been proved by the respondents on the balance of probabilities. The burden to prove the causative link fell on the respondents and they had not discharged the H standard of proof on the balance of probabilities. (para 121)

(5) The standard requirement which a medical doctor is required to adhere to before prescribing any medicine to a patient would relate only to the common effect of the drug I concerned. This was complied with by Dr. Gun. Even though Dr. Gun did not give a specific warning pertaining to the risk

of the incidence of Steven-Johnson Syndrome after taking Fansidar, she did inform Ranjini and Ranjini's mother about the common side effects of prescribing Fansidar and that constituted reasonable disclosure. (para 128)

(6) No medical practitioner is liable in negligence just because another doctor of greater skill and knowledge would have prescribed a different treatment or prescribed a different medicine. The prescription of Fansidar to Ranjini, being the drug of choice for the treatment of by Dr. Gun, could not on the balance of probabilities, based on the evidence adduced, make Dr. Gun liable in negligence. (para 140)

Bahasa Malaysia *Translation Of Headnotes*

Responden kedua ('Ranjini') adalah anak perempuan responden pertama. Ranjini merupakan pesakit di Hospital Seremban dan telah dirawat oleh perayu pertama/defendan ('Dr. Gun'), seorang pakar perunding dan reumatologi. Pada 16 Mei 2003, Ranjini telah dimasukkan dalam wad di Hospital Seremban kerana mengadu batuk dan demam berterusan. Pelbagai ujian oleh pakar-pakar dijalankan tetapi punca penyakit masih tidak dapat dikenal pasti. Pada 19 Ogos 2003, Dr. Gun, selepas meneliti keputusan ujian dan mengambil kira bahawa Ranjini tinggal di hostel sekolah yang mana mempunyai banyak kucing, membuat diagnosis sementara 'toxoplasmosis', satu jangkitan yang berpunca daripada parasit 'toxoplasma gondii' yang boleh dijumpai dalam najis kucing. Dr. Gun memberi preskripsi 'Fansidar' kepada Ranjini yang merupakan ubat pilihan bagi toxoplasmosis, hingga kini. Dos ubat Fansidar bagi Ranjini diputuskan selepas merujuk kepada ahli farmasi hospital. Dr. Gun memberi keterangan bahawa dia ada memaklumkan Ranjini dan responden pertama akan kesan sampingan Fansidar. Walau bagaimanapun, keadaan Ranjini tidak berubah. Pada 3 September 2003, Ranjini mengalami sindrom Steven-Johnson. Atas permintaan bapa Ranjini, dia dikejarkan ke Pusat Perubatan Universiti Malaya ('PPUM') bagi rawatan lanjut. Ranjini menjadi buta pada kedua-dua belah mata. Selepas rawatan, penglihatan pada mata kanannya kembali tetapi mata kirinya kekal buta. Dengan itu, satu tindakan di bawah kecuaian perubatan dihadapkan oleh responden-responden terhadap perayu-perayu. Hakim Mahkamah Tinggi membenarkan tuntutan responden-responden dan memerintahkan ganti rugi agar ditaksirkan oleh Penolong Kanan Pendaftar. Perayu-perayu merayu terhadap keputusan tersebut.

Diputuskan (membenarkan rayuan dengan kos):

(1) Berhubung isu mengenai apa yang menjadi kewajipan dan standard berhati-hati seorang pengamal perubatan dan kes kecuaian perubatan, dalam jurisprudens Malaysia, *Foo Fio Na v. Dr. Soo Fook Mun & Anor* menjadi ikutan bagi mahkamah. Ujian *Bolam* tidak seharusnya terpakai kepada semua aspek kecuaian perubatan. Menurut *Foo Fio Na (supra)*, ujian *Bolam* 'tidak relevan'. Walaupun undang-undang Inggeris menerima bahawa ujian *Bolam* terpakai kepada diagnosis dan rawatan, namun ia masih keberatan untuk meluaskan ujian *Bolam*.

(2) Dalam memastikan standard berhati-hati seorang pengamal perubatan dalam rayuan kecuaian perubatan, adalah menjadi hemat untuk menerima pendapat-pendapat doktor-doktor yang berkepakaran khusus dalam sains perubatan, untuk membantu mahkamah dalam mencapai keputusan yang adil selepas menilai keterangan yang dikemukakan oleh pihak-pihak.

(3) Ini bukanlah suatu kes di mana Dr. Gun membuat keputusan untuk memberikan preskripsi Fansidar kepada Ranjini tanpa merujuk pakar-pakar perunding yang lain. Hakikatnya, ia adalah kes yang mana selepas penelitian dan perbicangan telah dibuat secara menyeluruh, diagnosis dan rawatan dibuat.

(4) Preskripsi dan pengambilan Fansidar bukanlah punca Ranjini menghidap sindrom Steven-Johnson. Perkaitan kausa antara kecuaian perubatan dengan kecederaan yang didakwa tidak dibuktikan oleh responden-responden atas imbangan kebarangkalian. Beban membuktikan perkaitan kausa jatuh ke atas responden-responden dan mereka tidak melepaskan standard pembuktian atas imbangan kebarangkalian.

(5) Keperluan standard yang harus dipatuhi oleh seseorang doktor perubatan sebelum memberi preskripsi ubat kepada pesakit hanyalah berhubung dengan kes sampingan biasa dadah berkenaan. Ini telah dipatuhi oleh Dr. Gun. Walaupun Dr. Gun tidak memberikan amaran khusus bagi risiko berlakunya sindrom Steven-Johnson selepas mengambil Fansidar, tetapi dia ada memaklumkan Ranjini dan ibu Ranjini akan kesan sampingan biasa selepas preskripsi Fansidar dan ini membentuk satu pendedahan munasabah.

(6) Tiada pengamal perubatan yang bertanggungan dalam kecuaian hanya kerana seorang lagi doktor yang mempunyai kepakaran dan pengetahuan yang lebih tinggi, akan memberi preskripsi rawatan lain atau memberi ubat lain. Preskripsi Fansidar kepada Ranjini, iaitu ubat yang menjadi pilihan untuk rawatan bagi toxoplasmosis oleh Dr. Gun, tidak boleh, atas imbangan kebarangkalian, berdasarkan keterangan yang dikemukakan, menjadikan Dr. Gun bertanggungan dalam kecuaian.

Case(s) referred to:

Ang Yew Meng & Anor v. Dr Sashikannan Arunasalam & Ors [2012] 3 CLJ 937 HC ***(refd)***

Arulappan Kannan v. Dr Suresh Chopra & Ors [2011] 3 CLJ 662 HC ***(refd)***

Bolam v. Friern Management Committee [1957] 2 All ER 118 ***(refd)***

Bolitho (administratrix of the estate of Bolitho (deceased)) v. City and Hackney Health Authority [1997] 4 All ER 771 ***(refd)***

Cassidy v. Ministry of Health [1951] 2 KB 343 ***(refd)***

Chien Tham Kong v. Excellent Strategy Sdn Bhd & 2 Ors [2008] 1 LNS 411 HC ***(refd)***

Chin Keow v. Government of Malaysia & Anor [1967] 1 LNS 25 PC ***(refd)***

Dominic Puthucheary & Ors v. Dr Goon Siew Fong & Anor [2007] 5 CLJ 38 CA ***(refd)***

Dr Chai Hoon Seong v. Wong Meng Heong [2009] 10 CLJ 118 HC ***(refd)***

Dr Chin Yoon Hiap v. Ng Eu Khoon & Ors & Other Appeals [1998] 1 CLJ 533 ***(refd)***

Dr Ismail Abdullah v. Poh Hui Lin [2009] 7 CLJ 167 HC ***(refd)***

Elizabeth Choo v. Government of Malaysia & Anor [1960] 1 LNS 24 HC ***(refd)***

F v. R [1983] 33 SASR 189 ***(refd)***

Foo Fio Na v. Dr Soo Fook Mun & Anor [2007] 1 CLJ 229 FC ***(refd)***

Hasan Datolah v. Kerajaan Malaysia [2010] 5 CLJ 764 CA ***(refd)***

Hong Chuan Lay v. Dr Eddie Soo Fook Mun [1998] 5 CLJ 251 HC ***(refd)***

Hor Sai Hong & Satu Lagi lwn. Universiti Hospital & Satu Lagi [2001] 8 CLJ 208 HC ***(refd)***

Kamalam Raman & Ors v. Eastern Plantation Agency (Johore) Sdn Bhd & Ors [1997] 5 CLJ 250 HC ***(refd)***

Kow Nan Seng v. Nagamah & Ors [1981] 1 LNS 208 FC ***(refd)***

Lechemanavasagar S Karuppiah v. Dr Thomas Yau Pak Chenk & Anor [2008] 3 CLJ 76 HC ***(refd)***

Mahon v. Osborne [1939] 2 KB 14, [1939] 1 All ER 535 ***(refd)***

Mathew Scott Oakley & Ors v. Dr George Varughese & Anor [2010] 10 CLJ 322 HC ***(refd)***

Naxakis v. Western General Hospital And Another [1999] HCA 22 ***(refd)***

Payremalu Veerappan v. Dr. Amarjeet Kaur & Ors [2001] 4 CLJ 380 HC ***(refd)***
Pembangunan Maha Murni Sdn Bhd v. Jururus Ladang Sdn Bhd [1985] 1 LNS 122 SC ***(refd)***
Rex v. Bateman [1925] 94 LJKB 791 ***(refd)***
Rogers v. Whitaker [1992] 175 CLR 479 ***(refd)***
Rosenberg v. Percival [2001] 178 ALR 577 ***(refd)***
Sidaway v. Bethlem Royal Hospital Governors and Others [1985] 1 All ER 643 ***(refd)***
State of Haryana v. Bhagirath and Others [1999] Cri LJ 2898, AIR [1999] SC 2005 ***(refd)***
Steven Jaskoviak v. Daniel Gruver, MD and Medcenter One Health Systems 638 NW 2d 1, 2002 ND1 ***(refd)***
Wilsher v. Essex Area Health Authority [1988] 1 All ER 871 ***(refd)***

Legislation referred to:
Evidence Act 1950, ss. 56, 57
Government Proceedings Act 1956, ss. 5, 6

Other source(s) referred to:
Dieter Giesen, *International Medical Malpractice Law: A Comparative Study of Civil Responsibility Arising from Medical Care*, London: Sweet and Maxwell, 1988, p 163
Shane Bullock, Elizabeth Manias & Alan Galbraith, *Fundamentals of Pharmacology*, 5th edn, p 33

For the appellants/defendants - Zaliha Mohd Janis; SFC
For the respondents/plaintiffs - Silas Seenivasagam (Kasthury Sellapan with him); M/s Azariah & Assocs

[Appeal from High Court, Seremban; Civil Suit No: 21-8-2006]

Reported by Amutha Suppayah

JUDGMENT

Abdul Malik Ishak JCA:

Introduction

[1] This was an action in medical negligence brought by the respondents against the appellants. The trial before the High Court Judge was focused on liability only. After the trial, the High Court Judge allowed the respondents' claim against the appellants and ordered damages to be assessed by the Senior Assistant Registrar ("SAR"). The appellants were also ordered to pay the costs of RM15,000 to the respondents.

[2] This appeal was filed by the appellants before damages could be assessed by the SAR.

The Parties

[3] The respondents were the plaintiffs before the High Court Judge. The second respondent by the name of "Ranjini" was, at the material time, only 16 years of age and she is the daughter of the first respondent by the name of "Kartar Kaur". Ranjini was a patient of Seremban Hospital and she was treated by the first appellant by the name of "Dr Gun".

[4] The second appellant is the "Pengarah Perubatan Hospital Seremban", while the third appellant is "Kerajaan Malaysia", which is the employer of both Dr Gun and Pengarah Perubatan Hospital Seremban. That makes Kerajaan Malaysia vicariously liable for the negligent acts of Dr Gun and Pengarah Perubatan Hospital Seremban based on ss. 5 and 6 of the Government Proceedings Act 1956, provided that the respondents succeeded in proving that Dr Gun and Pengarah Perubatan Hospital Seremban were liable in this medical negligence suit.

The Facts

[5] Dr Gun narrated the medical history of Ranjini during her examination-in-chief. It was to the following effect.

[6] On 16 May 2003, Ranjini was warded at Seremban Hospital with complaints of persistent cough with yellowish sputum for five days and fever. She also complained of gum bleeding, on and off, for two months with minimal amount. There was no history of any drug allergy.

[7] On examination, it was found that Ranjini had a fever of 38.5 degree centigrade with injected throat. There was no cervical lymphadenopathy and no petechiae rash. Her other systems like the heart, lung and abdomen were normal.

[8] Initial investigations on 16 May 2003 showed that Ranjini's haemoglobin was 5.9, total white blood cells at 2.8 and platelet at 6,000.

[9] On 17 May 2003, repeated blood count was done and it showed that all was normal.

[10] Numerous tests were carried out and nothing significant was shown. She was treated as having an upper respiratory tract infection and was given an antibiotic (unasyn) and panadol or paracetamol. Her fever settled within a day in the ward.

[11] Subsequent investigations which included full blood count, sputum culture, sputum AFB, dengue IGM, renal function, liver function and urine examination, were all normal. On 20 May 2003, Ranjini was discharged. The specialist who saw Ranjini then was Dr C Gandhi and the consultant was Dato' Dr Thayaparan, the head of department then.

[12] On 7 July 2003, Ranjini was again admitted into Seremban Hospital with complaint of painful swelling on the right side of her neck which had progressively increased in size over the previous two months. Initially the swelling was pea size and now grew to the size of a 50 cent coin. She also complained of having fever with chills and rigors, on and off, as well as pain upon swallowing. Investigations revealed that there was no sore throat, no ear and nasal symptoms, no night sweat, no hair loss and no weight loss. Her appetite too was normal and there was no history of contact with a tuberculosis (TB) patient.

[13] Physical examinations showed that Ranjini had multiple enlarged right cervical lymph nodes which were mildly tender on palpation and firm in consistency. Her overlying skin was normal and the examination of her other systems were normal. She was also treated with a course of antibiotic (cloxacilin) while awaiting for the results of the other investigations.

[14] Ranjini was also referred to the ear, nose and throat ("ENT") department for the purpose of excluding any ENT pathology. On 10 July 2003, it was confirmed that she had no ENT pathology.

[15] She was also referred to the surgical unit for lymph nodes biopsy. She was well and afebrile three days after staying in the ward. The investigation results were as follows:

(a) blood culture (no growth);

(b) blood film for malaria (negative);

(c) urine FEME (normal);

(d) ANA (negative);

(e) C3 C4 (normal);

(f) WWF (normal); and

(g) CRP (normal).

[16] The breakdown of Ranjini full blood counts were as follows:

(a) total white count 3,600;

(b) haemoglobin 10.6; and

(c) platelet count 154,000.

[17] Ranjini remained afebrile for two days in the ward and on 11 July 2003, she was discharged and allowed to go home. She was given an appointment on 15 July 2003 to see Mr Sudirman for the lymph nodes biopsy. She was also given an appointment to come back to the medical clinic in a month's time. The medical officer in charge then was Dr Nadiah, while the specialist was Dr Esha Das Gupta and the consultant was Dato' Dr Thayaparan.

[18] On 17 July 2003, Ranjini was admitted to the surgical ward for the lymph nodes biopsy as scheduled. During that admission, no fever was noted. She was discharged from the ward in the evening of the same day.

[19] On 13 August 2003, Ranjini went to Seremban Hospital to review the lymph nodes biopsy result. It was reported that the lymph nodes was a reactive lymphoid hyperplasia and there was no evidence of malignancy. And since Ranjini was still complaining of having a fever then, she was electively admitted through the medical clinic on 13 August 2003. Dr Nadiah attended to her for her prolonged fever with right cervical lymphadenopathy (swelling of lymph nodes on the right neck).

[20] On 14 August 2003, Dr Gun first met Ranjini in the ward when the good doctor was doing her morning ward round. In answering the question as to why Dr Gun prescribed the drug "Fansidar" at that point of time, the good doctor replied in this way (see pp. 100 to 101 of the appeal record at vol. 2(1), parts "B" and "C"):

A7: I first saw her on 14/08/2003 at 10.15 am, I went through the above medical histories as presented above, apart from fever she also had vomitting on and off. Physical examinations showed a temperature of 38.5C and a few discrete right cervical lymph nodes, which were firm, mobile, and not fixed. There was no other lymph node enlargement elsewhere, and all other systems were normal.

The repeat CXR and the connective tissue screening test were normal. Inflammatory markers such as CRP and ESR were not significantly raised. Repeated blood culture was normal. Hepatitis A, B, and C screening test were also normal. Sputum AFB and Sputum Culture were negative. Urine Culture had no growth, Thyroid function test was normal. Total White count was 4700, Hb was 10.7 and the platelet count was 167,000. The full blood pictures showed no significant pathology except for suggestion of iron deficiency. Echo cardiogram of the heart was normal. She was started on Erythromycin (EES) and i/v Ceftriazone in the ward. However, the high fever persisted this time, despite being on 6 days of EES and five days of Ceftriazone.

Finally the serology for serum to toxoplasmosis came back on 19/08/2003 as positive for IgM and negative for IgG, which suggested recent infection. There was no history of scratching by cats. However, as she was staying in a hostel and she said that there were lots of cats in the hostel, the provisional diagnosis of toxoplasmosis was made.

I prescribed Fansidar to the Second Plaintiff because Fansidar is the drug of choice for toxoplasmosis.

[21] Dr Gun was asked to explain the meaning of "toxoplasmosis" and what could have caused it, and she gave the following reply (see p. 101 of the appeal record at vol. 2(1), parts "B" and "C"):

A8: Toxoplasmosis is a parasitic disease occurs worldwide. It is caused by a single cell (protozoa) parasite called toxoplasma gondii. This organism is usually contracted by eating undercooked meat from infected animals. The parasite produces eggs only in cats, thus cats are the definitive host for toxoplasma gondii. So humans can acquire toxoplasmosis from direct contact with cats feces containing T gondii eggs. When a human ingested T gondii organism or its eggs, the

> parasite makes its way to various tissues – usually the muscle, but also the brain, the eyes, the heart, and lungs. The body makes antibodies against the organism. Majority of people are never aware that they have been infected even when symptoms developed and the symptoms may include fever, swollen lymph nodes, malaise, muscle ache, sore throat. In few cases, the cyst may form in the eye causing inflammation and vision problem.

[22] On 19 August 2003, Dr Gun, after reviewing the test results, made a provisional diagnosis for "toxoplasmosis". According to the good doctor, "toxoplasmosis" is an infection due to the parasite "toxoplasma gondii" which could be found in cat faeces as cats are known to be definitive host of the parasite. Symptoms for "toxoplasmosis" include enlarged lymph nodes in the head or neck, headache, fever, muscle pain and sore throat.

[23] On 19 August 2003, Dr Gun prescribed the drug "Fansidar" to Ranjini; and according to Dr Gun, that would be the drug of choice for "toxoplasmosis", even today.

[24] According to Dr Gun, the dosage of the drug "Fansidar" prescribed to Ranjini was decided after consulting the hospital's pharmacist. And that Ranjini was started on two tablets of "Fansidar" for two days and then followed by one tablet for a total of one month.

[25] In answering the question as to the condition of Ranjini after being given the drug "Fansidar", Dr Gun said that Ranjini was given a total of 12 doses in the ward, her fever settled soon after the drug "Fansidar" was started, she had no fever for more than 24 hours in the ward, and she was tolerating the drug rather well. On 23 August 2003, Ranjini was discharged and she was allowed to go home with instructions to continue consuming "Fansidar" four times a day for a month and then return for review at the medical clinic in a month's time.

[26] According to Dr Gun, "As with any other patient, the common side effect of the medicine prescribed was informed" (see p. 102 of the appeal record at vol. 2(1), parts "B" and "C"). And when the good doctor was asked, "What was informed to the second plaintiff (referring to Ranjini) about the common side effect of Fansidar?", the reply was (see p. 102 of the appeal record at vol. 2(1), parts "B" and "C"):

A12: I can't remember whether I informed the second plaintiff (referring to Ranjini) but I definitely informed the mother (referring to Kartar Kaur) about the common side effects of the drugs such as rash, nausea and diarrhea.

[27] When Dr Gun was asked, "Did you inform the second plaintiff (Ranjini) (and/or the mother (Kartar Kaur)) about the possible side effects of Steven-Johnson Syndrome?", the reply was to this effect (see p. 102 of the appeal record at vol. 2(1), parts "B" and "C"):

A13: No, because the incidence of Steven-Johnson Syndrome is so rare. In fact, in Medical Literature, the incidence of Steven- Johnson Syndrome, after taking Fansidar, has been quoted as 1.1 cases per million patients prescribed with Fansidar. Medically, we doctors usually only inform the common side effect of any medicine to patients and not the uncommon or rare side effects.

[28] In another part of her evidence, Dr Gun testified that she did inform Ranjini and Kartar Kaur about the common side effect of Fansidar. Dr Gun's testimony was in this fashion (see p. 103 of the appeal record at vol. 2(1), parts "B" and "C"):

Q14: When did you inform the second plaintiff (referring to Ranjini) and/or the mother (referring to Kartar Kaur) about the common side effect of Fansidar?

A14: I informed them on the day I prescribed her the Fansidar, i.e. on 19.8.2003.

[29] On 30 August 2003, within a week of her discharge from Seremban Hospital, Ranjini was re-admitted with complaints of high grade fever for a day associated with chills and rigors and vomitting more than ten times that morning after returning from the march pass exercise at her school. Physical examination showed that she had a high grade temperature of 39.5 degree centigrade with increasing pain over the neck and there was a new tender lymph node over the right cervical region. However, there was no rash or no oral ulcer and her other systems were normal.

[30] Once again, a full round of medical investigations was performed. This time, investigations showed a TW count of 4,000, Hb of 9.5 and a platelet count of 254,000. The ESR was 33,

while PT/PTT was normal, and the renal and liver function tests were normal. However, the CRP was high at 19.6, while the blood film for malaria was negative and the blood culture showed no growth. The ANA was negative. A

[31] Dr Gun treated Ranjini as having sepsis and put her on I/V Maxipine and Fansidar was continued. Ranjini was also given intravenous fluids. And, at that point of time, there was no sign of Steven-Johnson Syndrome. B

[32] Dr Gun again saw Ranjini on 2 September 2003 at 11.35am and the good doctor noted that Ranjini was unable to tolerate anything orally. Examination revealed a few blisters in the oral cavity and injected conjunctive. Ranjini's cervical lymph nodes had also increased in number. C

[33] Dr Gun suspected straight away that the drug allergy was the cause of Ranjini's condition and ordered all the possible drugs such as Fansidar, Maxipine, Naproxen to be immediately stopped. D

[34] Ranjini was then given supportive therapy and referred to ENT, dermatology department and eye department for further assessments. E

[35] On the morning of 3 September 2003, Ranjini had developed Steven-Johnson Syndrome.

[36] At the request of Ranjini's father, she was sent to the University Malaya Medical Centre ("UMMC") for further treatment. That was on 3 September 2003 and the ambulance arrived at 2.30pm to send Ranjini to UMMC. And before the arrival of the ambulance, the doctors at Seremban Hospital gave her some IV kerosotisone, some IV vitamins and all supporting creams for the lip and the skin. F G

[37] Ranjini arrived at UMMC on 3 September 2003 at 7.30pm and was immediately rushed into a special room and was administered immunoglobulin for four consecutive days to stabilise her condition. H

[38] Ranjini's condition stabilised at UMMC. However, she suffered loss to her eye sight and became very depressed. She became blind in both eyes. I

[39] On 5 November 2003, at her own request, Ranjini was transferred to Seremban Hospital to be nearer to her family members.

[40] On 16 January 2004, Ranjini was transferred to the Kuala Lumpur General Hospital ("KLGH") where she was warded for about six months for ophtalmological care.

[41] At KLGH, Ranjini had to undergo several eye surgeries namely:

(a) on 18 February 2004 for right amniotic membrane transplant;

(b) on 13 March 2004 for left cornea lamellar graft under general anesthesia; and

(c) on 7 April 2004 for right conjuctival biopsy and conjuctival pedical graft.

[42] On 10 November 2005, Ranjini underwent a major surgical procedure known as Osteo-Odonto-Keratoprosthesis (hereinafter referred to as "OOKP") at the Singapore National Eye Centre.

[43] OOKP surgery is said to be the last resort treatment for severe ocular blindness. Associate Professor Donald Tan, the deputy medical director of the Singapore National Eye Centre, in his letter dated 3 November 2004 marked as exh. "P17" described OOKP surgery in this way:

> OOKP surgery involves the formation of an osteo-odonto lamina formed from a tooth fitted with an optical cylinder that acts as a lens and is inserted into a cornea on which buccal mucosa has been previously grafted.

[44] In exh. "P19", Dr Andrew BG Tay, the consultant with the department of oral and maxillofacial surgery of the Singapore National Dental Centre described OOKP procedure in this manner:

> The OOKP procedure is a last resort treatment for severe ocular blindness in which a canine tooth is ostectomised and prepared with the bone to carry an optical cylinder. This tooth-bone-optical cylinder complex (also called the keratoprosthesis) is then buried in the cheek. A buccal mucosal graft is also taken from the cheek and used to cover the affected eye. After several months, the keratoprosthesis is retrieved and implanted into the affected eye, underneath the buccal mucosal graft. The optical cylinder is therefore positioned to allow vision.

> A prerequisite for a successful OOKP procedure is a healthy canine tooth. Miss Ranjini has widespread gingivitis and oral ulcers, and requires a scaling and oral hygiene optimisation in preparation for OOKP surgery.

[45] The OOKP surgery at the Singapore National Eye Centre is a success. Ranjini now has vision in her right eye but her left eye remains blind.

Analysis

[46] What is the duty and standard of care of a medical practitioner in a medical negligence case? In answering this question, it is ideal, as a starting point to refer to the judgment of McNair J in *Bolam v. Friern Management Committee* [1957] 2 All ER 118, where His Lordship laid down the test at p. 122 in these erudite terms:

> A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.

[47] The test propounded by McNair J is famous in the common law world and it is known as the "*Bolam*" test.

[48] The standard of care, as set out in the *Bolam* test, is to be determined by the medical fraternity.

[49] But Lord Scarman in a strong dissenting judgment in *Sidaway v. Bethlem Royal Hospital Governors and Others* [1985] 1 All ER 643, HL, at p. 649 said:

> In short, the law imposes the duty of care; but the standard of care is a matter of medical judgment.

[50] In another part of his dissenting judgment, Lord Scarman in *Sidaway* had this to say (see p. 645 of the report):

> I am satisfied, for reasons which I shall develop, that the trial judge and the Court of Appeal erred in law in holding that, in a case where the alleged negligence is a failure to warn the patient of a risk inherent in the treatment proposed, the *Bolam* test, (see

A *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118, [1957] 1 WLR 582), to which I shall refer in detail at a later stage of my speech, is to be applied. In my view the question whether or not the omission to warn constitutes a breach of the doctor's duty of care towards his patient is to be
B determined not exclusively by reference to the current state of responsible and competent professional opinion and practice at the time, though both are, of course, relevant consideration, but by the court's view whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the
C relevant information whether or not she will accept the treatment which he proposes.

[51] What Lord Scarman in *Sidaway* held was that in relation to the medical advice by the doctor to the patient, it is the court
D and not the medical fraternity that will determine if the doctor has breached the standard of care in a medical negligence case.

[52] The dissenting judgment of Lord Scarman in *Sidaway* marked the beginning of the departure from the *Bolam* test.

E **[53]** In Australia, King CJ in *F v. R* [1983] 33 SASR 189, at p. 194 rejected the *Bolam* test when his Lordship said:

> The ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care
F demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community.

[54] The Australian High Court with a coram of Mason CJ,
G Brennan, Dawson, Toohey, Gaudron and McHugh JJ, in *Rogers v. Whitaker* [1992] 175 CLR 479, at p. 487 also rejected the *Bolam* test. There, the court said:

> In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is
H that of the ordinary skilled person exercising and professing to have that special skill. But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade. Even in the sphere of diagnosis and
I treatment, the heartland of the skilled medical practitioner, the

> *Bolam* principle has not always been applied. Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the *Bolam* principle has been discarded and, instead, the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to 'the paramount consideration that a person is entitled to make his own decisions about his life'.

[55] The Australian High Court speaking through Gleeson CJ in *Rosenberg v. Percival* [2001] 178 ALR 577, at p. 579 again rejected the *Bolam* test and held that:

> In many cases, professional practice and opinion will be the primary, and in some cases it may be the only, basis upon which a court may reasonably act. But, in an action brought by a patient, the responsibility for deciding the content of the doctor's duty of care rests with the court, not with his or her professional colleagues.

[56] The House of Lords in *Bolitho (administratrix of the estate of Bolitho (deceased)) v. City and Hackney Health Authority* [1997] 4 All ER 771 was concerned with the treatment of the patient by the doctor, and Lord Browne-Wilkinson, delivering the unanimous decision of the court had this to say (see p. 779 of the report):

> These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied on is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

[57] *Bolitho* acknowledges that the *Bolam* test remains applicable in cases of medical diagnosis and treatment, but in rare cases where the "professional opinion is not capable of withstanding logical analysis", it is the court who will determine if the doctor has breached the standard of care in medical law.

[58] The decision of the High Court of Australia in *Naxakis v. Western General Hospital And Another* [1999] HCA 22 followed *Rogers v. Whitaker* (*supra*). The decision of *Naxakis* discarded the *Bolam* test in regard to the diagnosis and treatment by the doctor to the patient and held that it is the court and not the medical fraternity that will determine whether the doctor has breached the standard of care in medical law.

[59] The Malaysian Courts vigorously applied the *Bolam* test in *Chin Keow v. Government of Malaysia & Anor* [1967] 1 LNS 25; [1967] 2 MLJ 45, PC; *Elizabeth Choo v. Government of Malaysia & Anor* [1960] 1 LNS 24; [1970] 2 MLJ 171; *Kow Nan Seng v. Nagamah & Ors* [1981] 1 LNS 208; [1982] 1 MLJ 128, FC; and *Hor Sai Hong & Satu Lagi lwn. Universiti Hospital & Satu Lagi* [2001] 8 CLJ 208; [2002] 5 MLJ 167.

[60] Abdul Malek Ahmad JCA (later the President of the Court of Appeal) writing for this court in *Dr Chin Yoon Hiap v. Ng Eu Khoon & Ors & Other Appeals* [1998] 1 CLJ 533; [1998] 1 MLJ 57, and after considering the relevant authorities, held that the "true test" establishing medical negligence on the part of a medical doctor would be the *Bolam* test.

[61] Richard Talalla J in *Kamalam Raman & Ors v. Eastern Plantation Agency (Johore) Sdn Bhd & Ors* [1997] 5 CLJ 250; [1996] 4 MLJ 674 applied *Rogers v. Whitaker* (*supra*) and held that it is the court and not the legal fraternity that will determine if the doctor has breached the standard of care in the diagnosis and treatment of the patient by the doctor. Clearly, his Lordship did not follow the *Bolam* test.

[62] James Foong J (later FCJ) in *Hong Chuan Lay v. Dr Eddie Soo Fook Mun* [1998] 5 CLJ 251, at p. 270; [1998] 7 MLJ 481, at p. 499 rejected the *Bolam* test and held that:

> Thus in considering whether a doctor has breached his duty in respect of the provision on information and advice, the court rather than a body of medical opinion shall be the judge of this issue.

[63] The Federal Court with a coram of Mohamed Dzaiddin Chief Justice, Ahmad Fairuz CJ (Malaya), and Siti Norma Yaakob FCJ reviewed the law on the standard of care in medical negligence in *Foo Fio Na v. Dr Soo Fook Mun & Anor* [2007] 1 CLJ 229. And the question of law that was posed to the Federal Court was worded in this way (see p. 237):

> Whether the '*Bolam* Test' as enunciated in *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118 in the area of medical negligence should apply in relation to all aspects of medical negligence.

[64] In answering this question of law, Siti Norma Yaakob FCJ writing for the Federal Court considered, *inter alia*, the *Bolam* test as well as cases like *Sidaway*, *Rogers v. Whitaker*, *Bolitho* and *Naxakis* and concluded at p. 258 of the report to the following effect:

> Therefore there is a need for members of the medical profession to stand up to the wrong doings, if any, as is the case of professionals in other professions. In so doing people involved in medical negligence cases would be able to obtain better professional advice and that the courts would be appraised with evidence that would assist them in their deliberations. On this basis we are of the view that the *Rogers v. Whitaker* test would be a more appropriate and a viable test of this millennium (than) the *Bolam* test. To borrow a quote from Lord Woolfe's inaugural lecture in the new Provost Series, delivered in London in 2001, the phrase 'Doctor knows best' should now be followed by the qualifying words 'if he acts reasonably and logically and gets his facts right'.

[65] The case of *Foo Fio Na* (*supra*) was followed by this court in *Hasan Datolah v. Kerajaan Malaysia* [2010] 5 CLJ 764; [2010] 2 MLJ 646 where Sulaiman Daud JCA, delivering the judgment of this court emphasised the responsibility of the court to decide whether the doctor has breached the standard of care in the diagnosis and treatment of the patient after evaluating the evidence adduced by the parties and after taking into account the medical evidence. At p. 654 of the MLJ reporting and at p. 772 of the CLJ reporting, this was what His Lordship said:

> ... we agree with learned counsel that *Foo Fio Na*, *supra*, had without doubt rejected the *Bolam* test in so far as it relates to the determination of the standard of care to be observed by a medical practitioner in a medical negligence suit. The right or responsibility

A to make such a determination now rests with the court upon evaluation of the evidence before it, including the opinion and practices of members of that profession.

[66] And his Lordship dismissed the patient's claim on the grounds that there was no negligence by the doctor and there was no proof of causation of the damage.

[67] Earlier on, in the later part of 2007, this court in *Dominic Puthucheary & Ors v. Dr Goon Siew Fong & Anor* [2007] 5 CLJ 38; [2007] 5 MLJ 552 had to consider the question of, *inter alia*, whether there was a breach of the standard of care in the diagnosis and treatment by the doctor to the patient. Gopal Sri Ram JCA, writing for this court, dismissed the appeal and applied *Foo Fio Na* (*supra*) because it was binding on this court.

[68] In our jurisprudence, *Foo Fio Na* (*supra*) is the guiding light for this court to follow. The Federal Court in *Foo Fio Na* (*supra*) was asked to answer the question of whether the *Bolam* test should apply in relation to all aspects of medical negligence and the Federal Court had answered it in the negative. In simple language, the Federal Court in *Foo Fio Na* (*supra*) said that the *Bolam* test should not apply to all aspects of medical negligence. And Siti Norma Yaakob FCJ confined the aspect of the *Bolam* test that has no relevance to the area of advice. At p. 246 of the report, this was what her Ladyship said:

> ... we are of the opinion that the *Bolam* test has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment.

[69] Put simply, according to *Foo Fio Na* (*supra*), the *Bolam* test has "no relevance" to advice.

[70] Speaking generally, although English law accepted that the *Bolam* test applies to diagnosis and treatment, yet it is reluctant to extend the *Bolam* test to advice. Indeed, Lord Scarman in *Sidaway*, in his dissenting judgment, was of the view that the *Bolam* test should not apply to advice.

[71] In *Foo Fio Na* (*supra*), Siti Norma Yaakob FCJ spoke of the duty of the medical practitioner in this way (see p. 246 of the report):

> The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment.

[72] I pause here to state that the decisions of *Hasan Datolah* (*supra*); *Kamalam Raman* (*supra*); *Arulappan Kannan v. Dr Suresh Chopra & Ors* [2011] 3 CLJ 662; *Dr Ismail Abdullah v. Poh Hui Lin* [2009] 7 CLJ 167; [2009] 2 MLJ 599 and *Ang Yew Meng & Anor v. Dr Sashikannan Arunasalam & Ors* [2012] 3 CLJ 937; [2011] 9 MLJ 153 treated the evaluation of expert professional opinions equally like any other evidence for consideration before the courts in medical negligence suits.

[73] In *Dr Ismail Abdullah* (*supra*), Azahar Mohamed J (now JCA) held that expert evidence "is a useful guide for courts". Supang Lian JC (now judge) in *Ang Yew Meng & Anor* (*supra*), at p. 176, aptly said that:

> What the profession does in the given situation will be an important indicator of what ought to have been done, but it should not necessarily be determinative. In the final analysis, the courts set the standard of care in negligence drawing upon the evidence presented.

[74] Post *Foo Fio Na* (*supra*), Rohana Yusof J (now JCA) in *Lechemanavasagar S Karuppiah v. Dr Thomas Yau Pak Chenk & Anor* [2008] 3 CLJ 76; [2008] 1 AMR 833 treated the evidence of the expert professional as influential or decisive, unless that expert professional opinion was not in compliance with reasonable, respectable and responsible practice.

[75] It is germane to mention that the case of *Lechemanavasagar* (*supra*) concerned the issues of advice and treatment by the doctor to the patient. And the patient lost his claim on the issue of causation.

[76] All these authorities are thought-provoking. They are certainly useful guidelines to consider in adjudicating the present appeal at hand.

[77] When Ranjini was first warded for high fever at the Seremban Hospital on 16 May 2003, she was not attended to by Dr Gun. Nevertheless, the doctors at the Seremban Hospital attended to Ranjini. And these doctors of the Seremban Hospital were the staff of Pengarah Perubatan Hospital Seremban. Medical examinations and tests were carried out followed by the necessary treatment and prescriptions of the relevant medicine. When Ranjini recovered, she was discharged on 20 May 2003. At that time, the specialist who attended to Ranjini was Dr C Gandhi and the consultant was Dato' Dr Thayaparan, who was also the head of department at that time.

[78] Again, on 7 July 2003, Ranjini was admitted into Seremban Hospital for high fever and she was not attended to by Dr Gun. Other doctors attended to Ranjini. Various tests were conducted and, on 10 July 2003, it was confirmed that Ranjini had no ENT pathology. On 11 July 2003, Ranjini became better and she was discharged. An appointment to see Mr Sudirman on 15 July 2003 for lymph nodes biopsy was arranged. At that time, Dr Nadiah, a medical officer, as well as Dr Esha Das Gupta and Dato' Dr Thayaparan attended to Ranjini.

[79] Notwithstanding the fact that Ranjini was supposed to undergo a lymph node biopsy on 15 July 2003, yet she underwent that procedure upon admission to the surgical ward on 17 July 2003. On that occasion, no fever was detected and Ranjini was discharged from the ward on the same day. Mr Sudirman and not Dr Gun who attended to Ranjini on 17 July 2003.

[80] On 13 August 2003, Ranjini went to Seremban Hospital to review her lymph nodes biopsy result and it was reported that it was not malignant. Ranjini still complained of having a fever and because of her complaint, she was admitted on 13 August 2003. It was Dr Nadiah who attended to Ranjini. Dr Gun did not attend to Ranjini on this occasion.

[81] Dr Gun's morning ward round on 14 August 2003 brought her, for the first time, to meet Ranjini. Dr Gun studied Ranjini's varied medical history and also ordered further tests to be conducted.

[82] On 19 August 2003, the serology for serum to "toxoplasmosis" came back as positive for IgM and negative for IgG which suggested recent infection.

[83] Taking into consideration the fact that Ranjini stayed at the school hostel where there were lots of cats, Dr Gun made the provisional diagnosis of "toxoplasmosis". According to Dr Gun, "toxoplasmosis" is an infection of the parasite "toxoplasma gondii" found in cat faeces as cats are the carrier of the parasite. And according to Dr Gun, enlarge lymph nodes in the head or neck, headache, fever, muscle pain and sore throat are symptoms for "toxoplasmosis".

[84] On 19 August 2003, Dr Gun started Ranjini on Fansidar.

[85] Dr Gun prescribed Fansidar to Ranjini because Fansidar is the drug of choice for "toxoplasmosis". In her evidence, Dr Gun stressed that even today, Fansidar is the drug of choice for "toxoplasmosis". The respondents plaintiffs did not challenge this piece of evidence.

[86] Dr Gun was very frank when she admitted that she could not remember whether she warned Ranjini of the side effect of Fansidar. However, Dr Gun testified that she definitely informed Ranjini's mother about the common side effects of the drugs such as rash, nausea and diarrhea. Dr Gun was more specific when she testified that on 19 August 2003, the day when she prescribed Fansidar to Ranjini, she informed both Ranjini and Ranjini's mother about the common side effect of Fansidar.

[87] The High Court Judge made a finding that Dr Gun failed to adequately and properly inform Ranjini or Ranjini's parents about the risk of side effect of the drug Fansidar before prescribing the said drug to Ranjini. At p. 14 of the appeal record at vol. 1, part "A", this was what the High Court Judge said:

> However, I find that the first defendant (referring to Dr. Gun) has failed to adequately and properly inform the second plaintiff (referring to Ranjini) or her parents (i.e. the second plaintiff's deceased father or PW3) on the risks of side effect of Fansidar before prescribing the same.

[88] The High Court Judge acknowledged that Dr Gun had informed Ranjini and Ranjini's mother - Kartar Kaur (PW3), about the side effect of Fansidar before prescribing it to Ranjini. Indeed, the evidence showed that on 19 August 2003 itself at that crucial moment, Dr Gun informed both Ranjini and her mother about the common side effect of Fansidar. However, Ranjini's father by the name of Govindasamy a/l Ponnusamy was not at the ward on 19 August 2003 and so Dr Gun was unable to speak to him about the prescription of the drug Fansidar and its common side effect.

[89] The High Court Judge continued to say at p. 15 of the appeal record at vol. 1, part "A":

> In my opinion, it is not sufficient for the first defendant to merely inform the second plaintiff or her parents about common side effects of the drugs such as rash, nausea and diarrhea. The first defendant should have also informed the plaintiffs of the dangerous effect of Steven-Johnson Syndrome. In my considered judgment, it is no defence for the first defendant to say that the side effect of developing a Steven-Johnson Syndrome is rare and therefore there was no necessity to inform the plaintiffs of the same.

[90] Her Ladyship held that the failure of Dr Gun to inform the respondents - referring to Ranjini and her parents, about the possible side effects of Steven-Johnson Syndrome after consuming Fansidar, was a crucial factor and the fact that it was rare for a patient to develop Steven-Johnson Syndrome was not a defence to be considered in favour of Dr Gun. We must be cautious. We are concerned with a medical negligence appeal. During the trial, the appellants called Dr Gun and Dr Nadiah to testify. The respondents initially wanted to call Professor Donald Tan, the deputy medical director of the Singapore Eye Centre as their witness but they changed their minds. The notes of evidence recorded by the High Court Judge at p. 143 of vol. 2(1), parts "B" and "C" showed the following state of affairs:

> Peguam Plaintif
>
> As requested, I pray for the Court to give me leave to call Professor Donald Tan to be examined on the procedure of the eye surgery. I think it is only fair that we call the doctor to explain the procedure further because my learned friend has brought up the issue on the second plaintiff not needing subsequent operations.

Mahkamah

Are you going to confine to specific areas?

Peguam Plaintif

Yes Yang Arif – only what the doctor operated on, eye part, it has nothing to do with the part where she was in Hospital Seremban. It was only what the process is about and what is the need for the subsequent operation in the Singapore National Eye Hospital.

Peguam Defendan

Pihak kami tak bantah. Cuma kami dibenarkan rebut.

[91] And at p. 144 of vol. 2(1), parts "B" and "C", the respondents' counsel informed the High Court Judge that they were not calling any expert witness. The recording showed this:

Peguam Plaintif

Tidak akan memanggil pakar. Pihak (kami) menutup kes pohon tarikh untuk penghujahan.

[92] It is salutary, at this juncture, to refer to the case of *Chien Tham Kong v. Excellent Strategy Sdn Bhd & 2 Ors* [2008] 1 LNS 411; [2009] 7 MLJ 261, a decision of Low Hop Bing J (later JCA). There, at p. 277 (MLJ), Justice Low Hop Bing succinctly said:

(60) Upon my analysis of the above authorities, I would apply the *Rogers* test, which has been accepted by the Federal Court in *Foo Fio Na* as it is binding on me. This test dictates that the court and not the medical profession must decide on the liability of doctors who are defendants in medical negligence actions. In so deciding, our courts are at liberty to reject medical evidence which does not really stand up to logical analysis, but instead must scrutinise and evaluate the relevant evidence in order to adjudicate on the appropriate standard of care. Due regard must be had to the relevancy of the opinion of experts in line with section 45(1) of the Evidence Act 1950, which provides that when the court has to form an opinion upon a point of eg science, the opinions upon that point of persons specially skilled in that science are relevant facts. In the context of the instant case, the opinions of doctors specially skilled in medical science, with particular speciality in spinal cords, neurology and stroke are relevant.

[93] It is not out of place to mention that the decision of Justice Low Hop Bing in *Chien Tham Kong* was dutifully followed by the High Courts in *Dr Chai Hoon Seong v. Wong Meng Heong* [2009] 10 CLJ 118; [2010] 8 MLJ 104, and *Mathew Scott Oakley & Ors v. Dr George Varughese & Anor* [2010] 10 CLJ 322; [2010] 2 AMR 326.

[94] In ascertaining the standard of care of a medical practitioner in a medical negligence appeal, like the present one at hand, it is always prudent to accept the opinions of doctors specially skilled in medical science, to assist the court in arriving at a just decision after evaluating the evidence adduced by the parties.

[95] Here, at the material time, Dr Gun was a consultant physician and rheumatologist. And when Dr Gun testified that the incidence of Steven-Johnson Syndrome after taking Fansidar was on a scale of 1.1 cases per million patients, it was unchallenged. There was no medical expert called by the respondents to rebut this. Dr Gun also cited a medical literature to support her assertions. In examination-in-chief, this was what Dr Gun testified as seen at p. 102 of the appeal record at vol. 2(1), parts "B" and "C":

> Q13: Did you inform the Second Plaintiff (and/or the mother) about the possible side effects of Steven-Johnson Syndrome?
>
> A13: No, because the incidence of Steven-Johnson Syndrome is so rare. In fact, in Medical Literature, the incidence of Steven-Johnson Syndrome, after taking Fansidar, has been quoted as 1.1 cases per million patients prescribed with Fansidar. Medically, we doctors usually only inform the common side effect of any medicine to patients and not the uncommon or rare side effects.
>
> Q13A: Can you show to the Court the Medical Literature that you are referring as to the 1.1 cases per million patients as quoted above?
>
> A13A: I'm referring to the Micromedex, Healthcare Series, which is often referred by Healthcare Professional for any uncommon and rare side effects of the medicine.
>
> P/Defendan: Pohon ditanda YA.
>
> Mahkamah: D31 DML.

[96] The Micromedex Healthcare Series marked as exh. "DML 31" can be seen, particularly at p. 695 of the appeal record, vol. 2(4), parts "B" and "C" and it was worded as follows:

> (C) Stevens-Johnson Syndrome
>
> (1) Incidence: rare
>
> (2) Pyrimethamine in combination with sulfadoxine (Fansidar (R)) has been reported to cause Stevens-Johnson Syndrome (SJS), ERYTHEMA MULTIFORME (EM), and toxic epidermal necrolysis (TEN). The incidence of SJS, EM, or TEN is estimated to be 1.1 cases per million patients prescribed Fansidar (R).

[97] Dr Gun explained that even the consumption of Panadol and Ponstan are risky for they could cause Steven-Johnson Syndrome. But, in normal practice, the rare adverse effects of consuming these drugs are not told to the patients. At p. 105 of the appeal record at vol. 2(1), parts "B" and "C", Dr Gun had this to say in her examination-in-chief in regard to this salient factor:

> Q22: Dr. Now that you are a very Senior Consultant in this field, can you inform the court of any other medicine that can cause a very rare adverse effect and where in normal practise the rare adverse effects are usually not informed to the patient?
>
> A22: I can give you two examples, the first one is Panadol or Medical Term is Acetaminophen and the second one is Ponstan Medical Term is Mefenamic Acid both I'm referring to the Micromedex, Healthcare Series which are often referred by Healthcare Professional and both also can cause Steven-Johnson Syndrome.

[98] According to Dr Gun, a simple Paracetamol (Panadol) can also lead to Steven-Johnson Syndrome.

[99] There was undisputed evidence which showed that Ranjini tolerated the drugs prescribed to her including the 12 doses of Fansidar well in the ward of Seremban Hospital and she was discharged on 23 August 2003 after having no fever for more than 24 hours.

[100] On 30 August 2003, Ranjini was re-admitted to Seremban Hospital. This time, she complained of having high grade fever for one day associated with chills and rigors and vomiting for more than ten times that morning after returning from the march pass at her school. Her other systems were normal and there was no rash nor oral ulcer. At that point of time, there was no sign of Steven-Johnson Syndrome.

[101] In her evidence, Ranjini mentioned that, on 30 August 2003, she felt feverish, vomited, had back and joint pain after coming back from the march pass. On 30 August 2003, Ranjini's main complaint was chest pain which was attended to by another doctor - not Dr Gun, and that doctor concluded that it was caused by muscle cramp.

[102] In examination-in-chief, Dr Gun was asked to comment about the allegations that she had been negligent in prescribing Fansidar to Ranjini and that she had failed to caution Ranjini about the side effect of Fansidar. Dr Gun responded in this way (see p. 104 of the appeal record, vol. 2(1), parts "B" and "C"):

> A18: I have clearly stated above on how we, the Medical team, came about the diagnosis of toxoplasmosis in the Second Plaintiff. We had extensively done all possible investigations in the hospital to look for possible causes of the patient PUO (Pyrexia of Unknown Origin) and the PUO persisted even after empirical antibiotics. The decision to treat as toxoplasmosis was made after consultation with other consultants based on clinical features (fever with lymphadenopathy), biochemical test (toxoplasma IgM positive) coupled with the fact that she stayed in the school hostel with plenty of cats. The usage of Fansidar, the drug of choice for treating this condition was hence justified. Even today the treatment is still the same. It is unfortunate that Second Plaintiff had developed Steven-Johnson Syndrome. As mentioned above, the adverse event of Fansidar causing Steven-Johnson Syndrome is extremely rare and unpredictable that is 1.1 per million cases in some studies and 50% of cases, the cause is unknown.

[103] When asked about her relationship with Ranjini in her capacity as a doctor, Dr Gun was honest and truthful about the whole thing. Dr Gun was very professional in dealing with Ranjini's medical condition. This was what Dr Gun said at p. 105 of the appeal record, vol. 2(1), parts "B" and "C":

Q20: How do you describe your relationship with the Second Plaintiff then and now? A

A20: I found Ranjini's case was a very challenging one for us (Medical Department) and we did a lot of investigations and discussions among the consultants about the diagnosis and treatment. I also found her very interesting as she is an Indian girl who is able to speak and write fluent Mandarin and we used to converse in Mandarin with each other. That is why she got a lot of attention from me. Then, even after the unfortunate incident and after she was transferred back to Hospital Seremban, I still continue to visit her even though she was not under my care anymore and give her the utmost support including counselling. Subsequently after she was discharged from Hospital Seremban, she was supposed to go for follow up in Eye Department but she still come back to see me on and off to get her eye drops which she was supposed to get that from the Eye Department and not from Medical Department. B C D

Q21: Did you documented every single interaction that you have between you and your patient or in the case of a minor to the guardians or relatives? E

A21: No, it is impossible to note down everything.

[104] This was not the case where Dr Gun decided to prescribe Fansidar to Ranjini without consulting other consultants. Rather, it was a case where after thorough investigations and discussions, the diagnosis and treatment were made. F

[105] According to Dr Gun, the Seremban Hospital could not be 100% sure that Fansidar is the cause of Steven-Johnson Syndrome. The good doctor ventured to explain that 50% of cases indicated that the cause of Steven-Johnson Syndrome are idiopathic, that is, unknown. To augment her conclusion, Dr Gun made reference to a medical literature marked as exh. "DML 34" which can be seen at p. 714 of the appeal record, vol. 2(4), parts "B" and "C". G H

[106] The only way to treat Steven-Johnson Syndrome, according to Dr Gun, would be to take away all the offending drugs prescribed to Ranjini such as Fansidar, Machiphine and Neproxine. Ranjini was put on IV drips and Peritone was prescribed for her skin itchiness. That would be the standard care for Steven-Johnson Syndrome as well as other allergic reaction. I

[107] Dr Gun agreed that Steven-Johnson Syndrome constitutes dermatological emergency and that general physicians, just like dermatologists, were able to treat Steven-Johnson Syndrome as well.

[108] Dr Gun acknowledged that on 3 September 2003, Ranjini had developed the full blown Steven-Johnson Syndrome. The good doctor knew that the mortality rate for Steven-Johnson Syndrome would be 5% to 10% and that the patient could even go blind as a result of the Steven-Johnson Syndrome.

[109] Under cross-examination, Dr Gun testified that Ranjini's father was not at the ward on 2 September 2003 and that Dr Gun only met Ranjini's father on 3 September 2003. According to Dr Gun, she has been communicating with Ranjini's mother all the while about Ranjini's illness. Ranjini's mother was always at the ward with her.

[110] Again, the standard care for any allergic reaction which include Steven-Johnson Syndrome was explained by Dr Gun under cross-examination as seen at p. 119 of the appeal record, vol. 2(1), parts "B" and "C" as follows:

Q91: How do you normally treat patients with severe allergy?

A: We give supportive care and take off the offended drugs.

Q92: What kind of supportive care are you talking about doctor?

A: Supportive care is to take off the offended drugs and give patients if they can't tolerate orally, give them drips, symptomatic treat them, if they have rash give something for rash and they have itchiness give something for itchiness.

Q93: That is all?

A: That is (the) standard care for any allergic reaction.

Q94: Even Steven-Johnson Syndrome?

A: Yes.

[111] According to Dr Gun, the supportive care extended to Ranjini included referring to ENT, dermatology and eye departments.

[112] Once again, the same question cropped up during the cross-examination of Dr Gun as seen at p. 121 of the appeal record, vol. 2(1), parts "B" and "C":

Q105: Yes, Dr. Gun on 2.9.2003, she actually developed something else which (was) a drug allergy which had caused Steven-Johnson Syndrome, what I'm saying is, what other treatment that you accorded her?

A: The treatment (of) Steven-Johnson Syndrome I have repeated many times, is to take off the possible offended drugs and symptomatic.

[113] At UMMC, Ranjini was administered with immunoglobulin. And it was pointed out by learned counsel for the respondents that immunoglobulin had saved Ranjini's life. But Dr Gun retorted in her cross-examination that "nobody can say that for sure". Dr Gun even ventured to say that the drug "immunoglobulin is definitely controversial". When confronted with the question that upon administration of immunoglobulin, Ranjini did not die, Dr Gun retorted in cross-examination that the odds were 10% to 20% mortality. The exchanges between learned counsel for the respondents and Dr Gun can be seen at pp. 123 to 124 of the appeal record at vol. 2(1), parts "B" and "C" and they make for an interesting reading material:

Q124: Do you know what they gave her in University Hospital?

A: Yes, she was given IV Immunoglobulin which is not the drug of choice for patient with Steven-Johnson Syndrome, if you refer even now to USFDA, IV Immunoglobulin is not indicated for patient with Steven-Johnson Syndrome.

Q125: You are saying it is not the drug of choice is it?

A: No.

Q126: So are you saying that University Hospital is not correct in giving her Immunoglobulin?

A: Immunoglobulin is still controversial up to now, if you go through any literatures, not to say 2003 even today even IV hydro cord, is controversial, steroid is controversial, Immunoglobulin is definitely controversial.

Q127: I put you Dr. Gun, that Immunoglobulin, actually arrested the side effects and saved her.

A: Nobody can say that for sure.

Q128: But at least in this case she didn't die?

A: No, as you see 10 – 20% of mortality and 80% never died.

[114] Dr Gun confirmed that the drug immunoglobulin was available, at the material time, at Seremban Hospital. And the occasion did not present itself for administration of the drug at that point of time. The notes of evidence at pp. 128 to 130 of the appeal record at vol. 2(1), parts "B" and "C" bear this out:

Q166: This drug Immunoglobulin that was administered to her in University Hospital, is it a strong drug. What is it for?

A: Immunoglobulin the proper indication only for patient with otomino diseases, for patient with denbiri syndrome, and it's not written anywhere seen in Ministry Blue Book, for Steven-Johnson Syndrome.

Q167: Am I right in saying that it boosts the patient's immune system?

A: No. It can cause other problem. It is not FDA approved or ministry approved to be used for Steven-Johnson Syndrome.

Q168: So you didn't have the medicine in Hospital Seremban?

A: Of course we have in Hospital Seremban.

Q169: You have the medicine?

A: Of course we have.

Q170: But you didn't think of giving it to her?

A: At that moment in time, no.

Q171: Did you consult any specialist about it?

A: We only diagnosed patient of having Steven-Johnson Syndrome on 3.9.2003 in the morning and at that point of time, the parent already requested us to transfer the patient out from the Hospital.

Q172: But it was only later. Not that morning itself. It was 8.45 am?

A: Yes, we do the talking, we do the arrangement and at that point in time there was no indication to give patient IV Immunoglobulin.

Q173: Dr. Gun you said, the father of the patient, was listening to you, right when you explained to him, you said that yourself?

A: They just want to transfer the patient out.

Q174: Dr. Gun, since you know the patient's condition was so bad that she should be treated immediately, instead of waiting for the ambulance to come at 2.30 pm, so couldn't you have treated her from the time you saw her at 8.45, couldn't you have treated her?

A: What do you mean that we are not treating her?

Q175: No, if you have treated her with Immunoglobulin?

A: As I mentioned, Immunoglobulin is not indicated at that point in time.

Q176: So you did not give it to her even though you claimed you have it?

A: Yes, definitely we have.

Q177: You did not consult any other specialist?

A: I was seeing her with Dermatologist specialist, Dr. Najib, a consultant. He did not think it is indicated also.

[115] In re-examination, Dr Gun explained the reason for not administering the drug immunoglobulin to Ranjini at p. 137 of the appeal record, at vol. 2(1), parts "B" and "C" in these salient words:

Q16: You mentioned that Hospital Seremban has Immunoglobulin, why was she not given Immunoglobulin?

A: As I mentioned Immunoglobulin is not the drug of choice or not indicated for patient with Steven-Johnson Syndrome, I can give you literatures on this, it's not indicated and it is not FDA approved.

Q17: What is FDA approved?

A: Food and Drugs Association of United States.

[116] Dr Gun testified that every year, patients with Steven-Johnson Syndrome were all treated at Seremban Hospital. And that it was rare to see a Steven-Johnson Syndrome patient due to the drug Fansidar. Dr Gun further testified that it made no difference if the eye doctor were to see Ranjini on 2 September 2003 because the treatment was symptomatic. And at UMMC, the doctors there merely gave Ranjini simple eye drops. At p. 136 of the appeal record at vol. 2(1), parts "B" and "C", the testimony of Dr Gun at re-examination went along these lines:

Q11: Dr. You gave the impression that Steven-Johnson Syndrome is so, so rare?

A: Yes, we see them every year and it was also all treated.

Q12: In your evidence just now, you did mention about 1.1 per million for Fansidar patients, as per Fansidar, do you consider it is rare?

A: Yes of course. That is the first case we have seen Steven-Johnson Syndrome if it is due to Fansidar.

Q13: Just now you said that it won't make any difference if the eye doctor has seen the second plaintiff on 2.9.2003, why did you say that?

A: It is because the treatment again is symptomatic. Even when she went to University Hospital, the treatment was just a simple eye drop but the eye complication developed later.

[117] Dr Gun takes centre stage in this appeal. It is for the court to decide what is the appropriate standard of care after giving due weight to "the paramount consideration that Ranjini is entitled to make her own decision about her life" (to paraphrase and to borrow the words of *Rogers v. Whitaker* (*supra*) which was approved by our Federal Court in *Foo Fio Na* (*supra*)). But Ranjini was only 16 years of age at the material time. The doctor-patient relationship between Dr Gun and Ranjini developed over time and there was an element of trust. Evidence showed that on 19 August 2003, Dr Gun informed both Ranjini and her mother about the common side effect of "Fansidar". It was on 19 August 2003 that Dr Gun prescribed "Fansidar" to Ranjini which was the drug of choice then and even today to combat

"toxoplasmosis", when tests showed that Ranjini had "toxoplasmosis". The High Court Judge acknowledged that Dr Gun had informed Ranjini and Ranjini's mother about the common side effect of prescribing "Fansidar" to Ranjini. But the High Court Judge said it was "not adequate and not properly informed". We disagreed with the High Court Judge. Ranjini's mother was at the ward and she knew what had happened and what was happening to her daughter. Ranjini, an Indian girl, was conversant in Mandarin both written and oral. She got along fine with Dr Gun. They communicated with one another. There was an element of trust in their doctor-patient relationship. Despite her age, evidence showed that Ranjini was able to convey her predicament to the doctors at the Seremban Hospital.

[118] The High Court Judge also said that Dr Gun should have informed the respondents of the dangerous effects of Steven-Johnson Syndrome. We disagreed for the reasons set out hereinunder.

[119] Before us, we only have the medical evidence of Dr Gun in cold print. The respondents plaintiffs did not call any medical doctor to testify for them. We must consider Dr Gun's evidence because it is of great value to us. We must draw upon and rely on Dr Gun's evidence in cold print in adjudicating the present appeal. Being an expert, Dr Gun's evidence was consistent with the probabilities of the case.

[120] The Supreme Court of India in the case of *State of Haryana v. Bhagirath and Others* [1999] Cri LJ 2898, AIR [1999] SC 2005 made the following germane observations which must surely apply in assessing the evidence of Dr Gun:

> 17. The opinion given by a medical witness need not be the last word on the subject. Such opinion shall be tested by the Court. If the opinion is bereft of logic or objectivity, Court is not obliged to go by that opinion. After all opinion is what is formed in the mind of a person regarding a fact situation. If one doctor forms one opinion and another doctor forms a different opinion on the same facts it is open to the judge to adopt the view which is more objective or probable. Similarly if the opinion given by one doctor is not consistent with probability the Court has no liability to go by that opinion merely because it is said by the doctor. Of course, due weight must be given to opinions given by persons who are experts in the particular subject.

[121] Dr Gun testified that it could not be 100% sure that "Fansidar" is the cause of the Steven-Johnson Syndrome. And that 50% of cases indicate that the cause of Steven-Johnson Syndrome are idiopathic, that is, unknown. That being the case, in our judgment, the prescription and consumption of "Fansidar" was not the cause of Ranjini contracting the Steven-Johnson Syndrome. In our judgment, the causal connection between medical negligence and the "damage" alleged had not been proved by the respondents on the balance of probabilities.

[122] The respondents bear the burden of proof and the standard of proof is the civil standard on the balance of probabilities. In order to succeed in the medical negligence suit, the respondents have to demonstrate that Dr Gun caused or contributed to the Steven-Johnson Syndrome. This brings into sharp focus the issue of causation. In the main, causation is purely a question of fact. It is concerned with the physical connection between the negligence of Dr Gun and the damage sustained by Ranjini. The causal link must be established between Dr Gun's breach of duty and the damage sustained by Ranjini. The burden of proof is on Ranjini to prove that the damage she suffered was caused by Dr Gun's negligence. And it is not always easy to prove causation. In the words of Dieter Giesen in "*International Medical Malpractice Law: A Comparative Study of Civil Responsibility Arising from Medical Care*," London: Sweet and Maxwell, 1988, at p. 163, para. 268:

> Establishing the causal connection between medical negligence and the injury complained of is probably the most difficult task in medical malpractice litigation ...

[123] The "but for" test plays a significant role in causation. The question to pose is this, whether the damage would have occurred but for the negligence. Put differently, the negligent act must have been the necessary condition for the damage to be caused.

[124] The burden to prove the causative link falls on the respondents (*Wilsher v. Essex Area Health Authority* [1988] 1 All ER 871, HL) and they have not discharged the standard of proof on the balance of probabilities. VT Singham JC (later Judge) in *Payremalu Veerappan v. Dr Amarjeet Kaur & Ors* [2001] 4 CLJ 380, at p. 394, alluded to the burden of proving causation in these erudite terms:

> As to causation, it is relevant in cases of medical negligence to consider the causative link between the injury that was sustained by the plaintiff himself prior to seeking medical treatment and the act of the doctor in this case, the act of the first and second defendants but unfortunately this evidence was lacking. This court is of the view that the allegations of negligence pleaded under the particulars of negligence as set out in the statement of claim must be established by the plaintiff on the balance of probabilities unless there are positive proved facts from which the court could draw an inference of the causation.

[125] Dr Gun testified further that the incidence of Steven-Johnson Syndrome after taking "Fansidar" was on a scale of 1.1 cases per one million patients. And this piece of evidence was unchallenged. Dr Gun said that it was rare and it was because of this that she did not inform Ranjini or Ranjini's mother about the possible side effects of Steven-Johnson Syndrome. No reasons were advanced for us to disbelieve Dr Gun on these statistics since she produced medical literature to support her assertions.

[126] Was there really a need for Dr Gun to inform Ranjini or Ranjini's mother that the incidence of Steven-Johnson Syndrome after taking "Fansidar" was on a scale of 1.1 cases per one million patients? We would answer this question in the negative. It is ideal, at this juncture, to refer to a book entitled, "*Fundamentals of Pharmacology*", 5th edn., written by Shane Bullock, Elizabeth Manias and Alan Galbraith, printed by Pearson Education, Australia. At p. 33, under caption, "*Appropriate Disclosure of Information*", the learned authors wrote:

> Health professionals have a duty to inform their clients adequately of the effects, risks and complications arising from a proposed drug regimen.

[127] And continuing on the same page of the same book, the learned authors wrote:

> Regardless of whether a standard is used or not, the doctor and nurse should offer simple but thorough information about the common effects and problems of a drug regimen.

[128] Based on these write-ups, the standard requirement which a medical doctor is required to adhere to before prescribing any medicine to a patient would relate only to the common effect of the drug concerned. And this was complied by Dr Gun.

[129] There are passages appearing in the case of *Steven Jaskoviak v. Daniel Gruver, MD and Medcenter One Health Systems* 638 NW 2d 1, 2002 ND1 (Supreme Court of North Dakota) that merit reproduction. That was a case where the patient brought medical malpractice action against the surgeon and the hospital. Bruce B Haskell J, of the District Court, Burleigh County, South Central Judicial District granted summary judgment for the defendants. Aggrieved, the patient appealed. The Supreme Court, Sandstrom J, held that the fact in issue as to whether the surgeon failed to obtain the patient's informed consent to surgery precluded summary judgment. For starters, at para. 8 of *Steven Jaskoviak*, the following passage appears:

> The plaintiff in a medical malpractice action is generally required to establish through expert testimony the degree of care and skill required of a physician, and whether specified acts fall below that standard of care, unless a physician's activity constitutes a blunder so egregious that a layman is capable of comprehending its enormity.

[130] It was argued, flowing from the abovementioned passage, that the respondents plaintiffs failed to call a medical witness to state the standard which Dr Gun should adopt when prescribing the drug "Fansidar" to Ranjini.

[131] At para. 12 of the judgment of Steven Jaskoviak, the following passage appears:

> In medical malpractice action based on lack of informed consent, a causal connection exists only when adequate disclosure would have caused the patient to withhold consent to the particular course of treatment or procedure.

[132] It was argued that the probabilities that Ranjini and her mother would withhold consent to the prescription of "Fansidar" was unlikely bearing in mind that "Fansidar" is the drug of choice to treat "toxoplasmosis" then and even now.

[133] At para. 13 of the judgment of Steven Jaskoviak, a passage worth reproducing reads as follows:

> As an integral part of the physician's overall obligation to his patient, the physician generally owes a duty of reasonable disclosure of the available choices with respect to the proposed therapy and of the material and known risks potentially involved in each.

[134] Taking this passage into consideration, it was rightly argued that even though Dr Gun did not give a specific warning pertaining to the risk of the incidence of Steven-Johnson Syndrome after taking "Fansidar", yet she did inform Ranjini and Ranjini's mother about the common side effects of prescribing "Fansidar" and that constituted reasonable disclosure.

[135] At para. 14 of the judgment of Steven Jaskoviak, another pertinent passage deserves reproduction. It reads thus:

> In examining the materiality of a risk involved in a medical procedure, to determine whether its disclosure is required, courts employ a two-pronged analysis: (1) an examination of the existence and nature of the risk and the probability of its occurrence, and (2) a determination by the trier of fact of whether the risk is the type of harm which a reasonable patient would consider in deciding on medical treatment; the materiality of information about the risk of a potential injury is a function of the severity of the potential injury and of the likelihood it will occur.

[136] By way of a reiteration, after taking into account the above passage, it was argued that it was unlikely that Ranjini and her mother would withhold consent to the prescription of "Fansidar" to combat "toxoplasmosis" bearing in mind that, firstly, "Fansidar" is the drug of choice then and now, and, secondly, the incidence of Steven-Johnson Syndrome is on a scale of 1.1 cases per one million patients.

[137] Finally, at para. 15 of the judgment of Steven Jaskoviak, yet another passage of significance needs to be reproduced:

> A physician is not required to inform a patient of risks that are so remote as to be negligible even where the consequences may be severe, and is not required to inform the patient of a very minor consequence even though the probability is high.

[138] It was argued, based on the above passage, that the remoteness of the risk of contracting Steven-Johnson Syndrome cannot be overlooked.

[139] What do we expect Dr Gun to do when she was confronted with the hard truth that Ranjini had "toxoplasmosis"? Must Dr Gun refrain from prescribing "Fansidar", the drug of choice then and now, to Ranjini? Must Dr Gun ignore the fact that Ranjini had contracted "toxoplasmosis" and refuse to

prescribe "Fansidar" bearing in mind that there was no other alternative treatment? Confronted with the reality that Ranjini had "toxoplasmosis", Dr Gun, assisted by her medical team, in the performance of her duty prescribed "Fansidar". It was a brave medical decision that has now found its way to this court.

[140] It is trite that a medical practitioner must possess a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. In our judgment, Dr Gun fulfilled all these requirements. And no medical practitioner is liable in negligence just because another doctor of greater skill and knowledge would have prescribed a different treatment or prescribed a different medicine (*Rex v. Bateman* [1925] 94 LJKB 791, CCA; and *Mahon v. Osborne* [1939] 2 KB 14, at 31, [1939] 1 All ER 535, at 548, CA). In our judgment, the prescription of "Fansidar" to Ranjini, being the drug of choice then and now, for "toxoplasmosis" by Dr Gun, cannot on the balance of probabilities, based on the evidence adduced, make Dr Gun liable in negligence.

[141] It was also argued by the appellants defendants that the High Court Judge has placed a high burden on medical doctors and the impossibilities faced by the medical doctors in general in explaining the risks attached before prescribing drugs to their patients. Three paragraphs in the memorandum of appeal alluded to this ground. In her grounds of judgment, the High Court Judge had this to say at p. 15 of the appeal record, at vol. 1, part "A":

> (12) I think the time has come for the need for medical practitioner to fully inform his patient the full effect of any treatment or drugs he intended to prescribe to his patient.

[142] A clarion call was made by the High Court Judge that every medical doctor must explain the adverse effects of any drug to every patient before prescribing that drug to that patient. But there was no medical evidence from the respondents to support such a clarion call. Neither was there any medical evidence adduced by the respondents that it was inadequate and insufficient for Dr Gun to merely inform Ranjini and Ranjini's mother about the side effects of prescribing "Fansidar" to Ranjini. What cannot be disputed was that Dr Gun and the medical officers together with the other specialists at the Seremban

Hospital had treated Ranjini well based on the complaints and information obtained from Ranjini herself and from members of Ranjini's family, from the moment Ranjini stepped foot at Seremban Hospital until her exit to UMMC, which was acceded to at the behest of Ranjini's father.

[143] The clarion call by the High Court Judge, so to speak, has placed a heavier burden on every medical doctor to comply and it is not practical and it is impossible to comply. It is not an ideal scenario for every medical doctor to adhere to. Judicial notice can be taken that the medical services in the whole country would come to a grinding halt or move at a shower pace if every medical doctor is required to explain the adverse effects of any drug prescribed to every patient. Towards this end, we call in aid ss. 56 and 57 of the Evidence Act 1950 pertaining to judicial notice. We also rely on the principle of law that facts which are judicially noticed need not be proved (*Pembangunan Maha Murni Sdn Bhd v. Jururus Ladang Sdn Bhd* [1985] 1 LNS 122; [1986] 2 MLJ 30, 31, SC).

[144] In our judgment, from the available evidence, the respondents failed to prove, on the balance of probabilities, that Dr Gun and Pengarah Perubatan Hospital Seremban were liable in this medical negligence suit. That being the case, Kerajaan Malaysia cannot be held vicariously liable.

[145] This appeal was not like the case of *Cassidy v. Ministry of Health* [1951] 2 KB 343, where the Court of Appeal there confirmed that a hospital authority will be held vicariously liable for the negligence of all staff, nurses and doctors alike, employed under a contract of service as part of the permanent staff of the hospital. Denning LJ made it clear that a hospital is in the same position as any other employer in respect of the torts of its employees. At p. 360, Denning LJ had this to say:

> In my opinion authorities who run a hospital, be they local authorities, government boards, or any other corporation, are in law under the selfsame duty as the humblest doctor; whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves: they have no ears to listen through the stethoscope, and no hands to hold the surgeon's knife. They must do it by the staff they employ; and if their staff are negligent in giving the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him.

[146] The law on vicarious liability is now well-settled. It is appropriate to say that vicarious liability arises from the relationship between an employer and an employee, and it does not depend upon any personal fault of the employer. Liability is placed on the employer, not because of any breach of the employer's duty to the plaintiff claimant but rather because of the employee's breach of a duty owed by the employee to the plaintiff claimant.

[147] Here, on the facts, vicarious liability was not proved by the respondents against Kerajaan Malaysia.

[148] In answering the question of whether the evidence of Dr Gun could stand up to logical analysis, we would answer it in the positive. In our judgment, Dr Gun's professional opinion, as alluded to earlier, is capable of withstanding logical analysis. Dr Gun's evidence serves as a useful guide for this court to adjudicate on the liability of the appellants defendants. It is our judgment that Dr Gun's "conduct accords with the practices of her profession" and "it conforms to the standard of reasonable care demanded by the law" (borrowing the words of King CJ in *F v. R* (*supra*)).

[149] For the varied reasons alluded to in this judgment, we unanimously allowed the appeal of the appellants with costs of RM1,000. We set aside the decision of the High Court Judge.

[150] This judgment received the concurrence of Alizatul Khair binti Osman Khairuddin, JCA and Mohd Zawawi bin Salleh, JCA. And it is the judgment of this court.